Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Jack Deetjen, MD

Respondent Name
Texas Association of Counties RMP

MFDR Tracking Number
M4-15-1046-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was submitted to you for the patients MMI/IR exam. The MMI procedure code 99455-V4 is reimbursed at $350.00 and you paid $160.17. The IR procedure code 99455-WP is reimbursed at $300.00 and you paid $300.00. Therefore we are still due $189.83 for the procedure code 99455-V4."

Amount in Dispute: $189.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor, who is the claimant's treating doctor, billed $450.00 for an MMI exam under code 99455 WP, and this was properly reimbursed at $300.00, and the payment amount for this service is not in dispute. The Requestor also billed $450.00 for the impairment rating portion of the exam, under code 99455 V4, and this is the charge in dispute. The carrier paid based on 9455-V4 (99214) as follows: $102.92 x 1.5562714 = $160.17 and contends that this is the correct reimbursement amount. Accordingly, no further reimbursement should be ordered."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2014	Treating Doctor Examination to Determine MMI/IR	$189.83	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 247 – A payment or denial has already been recommended for this service.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - D1 – Duplicate Control Number 20331606

Issues

1. What is the correct MAR for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (j)(3) states, "The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) **Reimbursement shall be the applicable established patient office visit level associated with the examination.** (ii) Modifiers 'V1', 'V2', 'V3', 'V4', or 'V5' shall be added to the CPT code to correspond with the last digit of the applicable office visit" [emphasis added]. Review of the submitted documentation finds that the requestor billed 99455 V4, indicating that the "applicable established patient office visit level" is 99214.

   Procedure code 99214, service date June 19, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.5. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 0.916 is 1.29156. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.816 is 0.0816. The sum of 2.87316 is multiplied by the Division conversion factor of $55.75 for a MAR of $160.18.

   Therefore, the correct MAR for the disputed service is $160.18.
2. The total allowable for the services in dispute is $160.18. Review of the submitted documentation finds that the insurance carrier paid. $160.17. Therefore, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	March 2, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received

by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.